Report of Maine's 2006-2007
State Health Plan Telemedicine Workgroup
April 2008

Executive Summary

Telemedicine refers to the use of telecommunications technology – ranging from telephone to real-time video and internet connection – to provide health care services to patients who have physical or geographic difficulties in accessing services from physicians or other health care providers. It can be particularly useful in a rural state like Maine, where some health care services are distantly located from the community and where workforce challenges frequently limit access to many services.

Maine's 2006-07 State Health Plan created this workgroup "to develop strategies to help Maine achieve an appropriately-developed, utilized and reimbursed telemedicine infrastructure that serves the best interest of patients."[1]

The workgroup found that while certain communities have adopted telemedicine-use, in others there is a lack of interest on the part of doctors, patients, and employers.

This lack of interest is in part due to a lack of information about telemedicine, including lack of a well developed evidence-base regarding its costs and benefits – and thus a well-documented "business case" – for various services.

To address this and other issues, the workgroup's core recommendation is the creation of an ongoing forum in which telemedicine providers work together to:

(a) Increase understanding of telemedicine by (i) creating an evidence-base (which services telemedicine is used for; what the outcomes, costs and benefits are, etc.) to establish the business-case for telemedicine and share this information with insurers, providers, and employers, who do not currently use telemedicine; and (ii) educating patients and providers about telemedicine;

(b) share best practices with one another;

(c) discuss new and emerging technology; and

(d) coordinate with one another on applications for federal and other grants and to focus investment in services with the highest need and the most potential to improve patient health outcomes, so that telemedicine technology and services are deployed in a systematic way.

[1] 2006-07 State Health Plan, page 44.

Introduction

Telemedicine refers to the use of telecommunications technology – ranging from telephone to real-time video and internet connection – to provide health care services to patients who have physical or geographic difficulties in accessing services from physicians or other health care providers. It can be particularly useful in a rural state like Maine, where some health care services are distantly located from the community and where workforce challenges frequently limit access to many services, including, but not limited to, specialty services. This is especially true with time sensitive diagnoses – for example acute stroke – in which treatment windows are very short, and specialty providers are critical to the chain of survival and recovery.

The promise also exists for telehealth to advance health beyond improving access to services. Providers assert that tele-home-health services enhance self-care, medication management, and chronic disease management, therefore improving health and reducing rehospitalization rates. More commonly, telephone education has long been used to help patients learn how to better manage their diabetes.

Interested in the opportunity to improve access to care in rural communities, the Maine Health Access Foundation (MeHAF) convened a group of stakeholders in 2003 and 2005 with an interest in telemedicine and discovered that, while Maine has robust telemedicine infrastructure (i.e., the equipment, whose acquisition was largely funded by federal grants), telemedicine was not being widely used, due to a number of cited barriers, including: licensing; credentialing and privileging; and reimbursement.

Maine's 2006-07 State Health Plan created this Workgroup to look further into and address those barriers, with the goal of "develop[ing] strategies to help Maine achieve an appropriately-developed, utilized and reimbursed telemedicine infrastructure that serves the best interest of patients." Since its creation, the full Workgroup has met six times, and formed a number of committees to work on specific regulatory, policy, and infrastructure issues. Below is a summary of the work accomplished and recommendations for moving forward.

Accomplishments and Recommendations

Barrier 1. Lack of: Information, Interest, Familiarity, and Comfort

Through the course of its meetings, the Workgroup discovered that the biggest barrier to telemedicine-use appeared to be a lack of patient and provider interest in telemedicine services. In communities where a "champion" had emerged, telemedicine-use was higher, improving access and appearing to benefit patients.[2] In communities that lack a

[2] A number of Maine providers have used telehealth very successfully and developed large programs to address substantial patient need; e.g., Acadia behavioral health; St. Mary's wound care; Regional Medical Center at Lubec's telepharmacy program; Home Health's Visiting Nurses of Southern Maine and Community Health and Counseling Services home health services (see CD-ROM appendix for an inventory

telemedicine champion, the lack of interest seems to spring from the following "chicken or egg" dynamic:

(1) There is not widespread use telemedicine by patients and providers because
    (i) they have not been exposed to it and thus do not ask for it, and
    (ii) many payors (employers and insurers) do not pay for it;
(2) many employers and insurers do not pay for it because of
    (i) lack of a well-established evidence-base, the business case for using telemedicine for various services has not been made, and
    (ii) lack of interest from patients and providers; and
(3) a robust evidence-base cannot be built because too few patients and providers use telemedicine to generate the numbers necessary for a robust evidence-base.

While the workgroup has taken steps to address several regulatory barriers (see subsequent sections), the workgroup determined that the most significant way to increase appropriate use of telemedicine would be to address the "chicken or egg" dynamic by ***creating an ongoing forum in which telemedicine providers work together to design, collect, and share an evolving body of information on telemedicine – including building an evidence-base (which services it is used for; what the outcomes, costs and benefits are, etc) – and to share this information with insurers, providers, employers, and patients who do not currently use telemedicine and to inform future discussions on telemedicine-use***.

The data upon which to build the evidence-based would be supplied by providers of similar services agreeing to collect the same data – not just on patient satisfaction, but on outcomes and cost.[3] Participants could also conduct ongoing literature searches and keep apprised of developments in other states[4] to further this information-building and dissemination effort.

To the extent that resources permit, state government – the Maine Quality Forum, Maine Heath Data Organization, and DHHS's Office of MaineCare Services and Office of Rural Health and Primary Care – should be involved in supporting data collection, analysis, and dissemination of findings to payors, providers, and patients.

The workgroup also noted that most medical and nursing schools do not teach students about telemedicine, which contributes to provider lack of familiarity and comfort. ***The workgroup therefore recommends that Maine educational institutions' include examples of telemedicine in their training curricula to help address this issue.***

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of current telemedicine programs developed by the Regional Medical Center at Lubec's Northeast Telehealth Resource Center).

[3] See appendix nine for a matrix of outcome data being currently being collected by Workgroup participants.

[4] At least three states -- Georgia, Kentucky, and Texas -- mandate that all payors pay for telemedicine, so these states might be good sources of data.

Barrier 2. Payors' Telemedicine Policies

At the workgroup's outset, there was significant confusion about payor policies for telehealth services. The Workgroup clarified payor policies for telehealth services by collecting information from Maine payors: Cigna, Aetna, and Harvard Pilgrim each have a policy not to pay for provider/patient visits using distance technology,[5] while Medicare,[6] MaineCare, and Anthem do pay for some telehealth services (copies or summaries of these policies are included in appendix six).

A number of payors participating in the workgroup's meetings (Anthem, Cigna, Aetna, Harvard Pilgrim, and MaineCare) said that there is neither sufficient demand from patients, providers, and employers, nor sufficient data on the quality and effectiveness of telemedicine services for them to modify their reimbursement policies at this time.

The Workgroup researched the evidence base for using telehealth services and found that the Agency for Health Care Resources and Quality had commissioned two studies of the existing evidence base for telemedicine (see meeting notes in appendix four). While these studies found patient satisfaction to be high, the studies found there was not sufficient data to make any conclusions about outcomes.

As a result, a Data Collection and Analysis subgroup was formed to investigate outcome data currently being collected by Maine telemedicine providers, with the goal of using this data to build an evidence base for Maine. As seen in appendix nine, which provides a matrix showing the outcome data currently being collected, different providers collect different data, which precludes the building of a robust evidence base. The workgroup's recommendation on page 3 that telemedicine providers lead the effort and agree to collect the same data – not just on patient satisfaction, but on outcomes and cost – is the next step in building a telemedicine evidence base for Maine.

Barrier 3. State Regulatory Policies.

Licensing

The Licensing Committee looked at the extent to which DHHS regulations regarding paperwork and fire marshal requirements for telemedicine providers have served as a barrier to providing mental health services through telemedicine. At the subcommittee meeting, Peter Mauro, Assistant Director of DHHS's Division of Licensing and Regulatory Services (DLRS), clarified how the Department interprets current regulations, and Committee members indicated that a letter from the Department articulating this interpretation would succeed in addressing a perceived barrier that the regulations were overly burdensome. DLRS sent a letter to relevant providers in August 2007 (appendix

[5] Many plans do tend to pay for services such as radiology reading via distance technology.
[6] Center for Telehealth & E-Health Law. *Medicaid Policies on Telehealth Services: A Comparative Analysis.* Prepared for the Maine Health Access Foundation, June 2006, page 7.

seven). This letter should clarify current regulations and reduce regulatory barriers to telehealth adoption by the provider community.

Credentialing and Privileging

The Credentialing and Privileging Committee looked at institutions' credentialing and privileging processes for telemedicine services. It was pointed out that (1) while JCAHCO guidelines allow hospital reciprocal credentialing for telemedicine, Maine regulations do not, and that this could serve as a barrier to provision of services through telemedicine, and (2) DHHS's Division of Licensing and Regulatory Services (DLRS) is in the process of revising the hospital licensing rules. The Committee drafted a letter (appendix seven) to DLRS Director Cathy Cobb, urging DLRS to address the issue in its revisions. Specifically, the letter recommended allowing any hospital that has met federal conditions of participation to deliver care through telemedicine contracts with any other hospital that has met the federal conditions of participation, as long as the other hospital is licensed in Maine. As of the date of publication of this report, the rule revision was not yet complete – they are expected in July 2008 – but DHHS has indicated that the Committee's goal will be achieved by the revision's wider broader objective of granting licensure to any hospital that has met federal conditions of participation.

Barrier 4. Connectivity and Technology Infrastructure

The last committee created, the Technology Committee, discussed the need for improved connectivity, ongoing improvements in Maine's telehealth infrastructure, and the need to better understand who had what technology, capacity, and resources around the state. At the committee's request, the New England Telemedicine Resource Center put together an impressive inventory of telehealth programs and technology around the state. That information can be found in appendix eight and on the CD-ROM appendix to this report.

In November 2007, two Maine groups were awarded federal grants that should significantly improve connectivity. Specifically, the New England Telehealth Consortium – a group of providers convened by ProInfoNet of Bangor that includes 555 rural and healthcare sites in Maine, New Hampshire, and Vermont (with the vast majority of the sites in Maine) – received a three-year $24.6 million grant from the Federal Communications Commission to lay down the broadband lines necessary to create telemedicine connectivity between the teaching centers, tertiary, secondary, and critical access hospitals, Federally Qualified Health Centers, Rural Health Clinics, and other providers that belong to the consortium

The FCC also awarded a $3.6 million grant under the same program to the Rural Western and Central Maine Broadband Initiative, a collaborative proposal involving Franklin Community Health Network, HealthReach Network Community Health Centers, and Central Maine Healthcare

By developing the broadband infrastructure over which telemedicine is transmitted,

connectivity will be much improved. However, while connectivity is vital, the current telemedicine infrastructure, like all technology, is aging quickly. New investments will need to be made on an ongoing basis. In the past, the Federal government has funded much of the equipment used in the state. Without more patient and provider demand for telemedicine – and without the evidence-base to document a clear business-case for telemedicine – additional investment in technology, staff training, and program development will be harder to justify over time.

Therefore, the Workgroup makes its final recommendation:

The issue of technology is best addressed in a coordinated manner, across organizations and health systems, in a way to improves access to care where it is needed most. This requires frequent collaboration between and among many organizations, a coordinated application process for available grants that improves the needed infrastructure in the state, and a focused investment in services with the highest need and the most potential to improve patient health outcomes. The forum recommended on page 3 should be used to discuss and facilitate this important coordination.